

the absence of privity of contract between a third party payer and a facility of the uniformed services is not a permissible ground for refusing or reducing third party payment.

(5) *Medicare carve-out and Medicare secondary payer provisions.* A provision in a third party payer plan, other than a Medicare supplemental plan under § 220.10, that seeks to make Medicare the primary payer and the plan the secondary payer or that would operate to carve out of the plan's coverage an amount equivalent to the Medicare payment that would be made if the services were provided by a provider to whom payment would be made under Part A or Part B of Medicare is not a permissible ground for refusing or reducing payment as the primary payer to the facility of the Uniformed Services by the third party payer unless the provision:

(i) Expressly disallows payment as the primary payer to all providers to whom payment would not be made under Medicare (including payment under Part A, Part B, a Medicare HMO, or a Medicare+Choice plan); and

(ii) Is otherwise in accordance with applicable law.

[55 FR 21748, May 29, 1990, as amended at 57 FR 41101, Sept. 9, 1992; 65 FR 7728, Feb. 16, 2000]

§ 220.4 Reasonable terms and conditions of health plan permissible.

(a) *Statutory requirement.* The statutory obligation of the third party to pay is not unqualified. Under 10 U.S.C. 1095(a)(1) (as noted in § 220.2 of this part), the obligation to pay is to the extent the third party payer would be obliged to pay if the beneficiary incurred the costs personally.

(b) *General rules.* (1) Based on the statutory requirement, after any impermissible exclusions have been made inoperative (see § 220.3 of this part), reasonable terms and conditions of the third party payer's plan that apply generally and uniformly to services provided in facilities other than facilities of the uniformed services may also be applied to services provided in facilities of the uniformed services.

(2) Except as provided by 10 U.S.C. 1095, this part, or other applicable law, third party payers are not required to

treat claims arising from services provided in or through facilities of the Uniformed Services more favorably than they treat claims arising from services provided in other facilities or by other health care providers.

(c) *Specific examples of permissible terms and conditions.* The following are several specific examples of permissible terms and conditions of third party payer plans. These examples are not all inclusive.

(1) *Generally applicable coverage provisions.* Generally applicable provisions regarding particular types of medical care or medical conditions covered by the third party payer's plan are permissible grounds to refuse or limit third party payment.

(2) *Generally applicable utilization review provisions.* (i) Reasonable and generally applicable provisions of a third party payer's plan requiring pre-admission screening, second surgical opinions, retrospective review or other similar utilization management activities may be permissible grounds to refuse or reduce third party payment if such refusal or reduction is required by the third party payer's plan.

(ii) Such provisions are not permissible if they are applied in a manner that would result in claims arising from services provided by or through facilities of the Uniformed Services being treated less favorably than claims arising from services provided by other hospitals or providers.

(iii) Such provisions are not permissible if they would not affect a third party payer's obligation under this part. For example, concurrent review of an inpatient hospitalization would generally not affect the third party payer's obligation because of the DRG-based, per-admission basis for calculating reasonable charges under § 220.8(a) (except in long stay outlier cases, noted in § 220.8(a)(4)).

(3) *Restrictions in HMO plans.* Generally applicable exclusions in Health Maintenance Organization (HMO) plans of non-emergency or non-urgent services provided outside the HMO (or similar exclusions) are permissible. However, HMOs may not exclude claims or refuse to certify emergent and urgent services provided within the HMO's service area or otherwise covered non-

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emergency services provided out of the HMO's service area. In addition, opt-out or point-of-service options available under an HMO plan may not exclude services otherwise payable under 10 U.S.C. 1095 or this part.

(d) *Procedures for establishing reasonable terms and conditions.* In order to establish that a term or condition of a third party payer's plan is permissible, the third party payer must provide appropriate documentation to the facility of the Uniformed Services. This includes, when applicable, copies of explanation of benefits (EOBs), remittance advice, or payment to provider forms. It also includes copies of policies, employee certificates, booklets, or handbooks, or other documentation detailing the plan's health care benefits, exclusions, limitations, deductibles, co-insurance, and other pertinent policy or plan coverage and benefit information.

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§ 220.5 Records available.

Pursuant to 10 U.S.C. 1095(c), facilities of the uniformed services, when requested, shall make available to representatives of any third party payer from which the United States seeks payment under 10 U.S.C. 1095 for inspection and review appropriate health care records (or copies of such records) of individuals for whose care payment is sought. Appropriate records which will be made available are records which document that the services which are the subject of the claims for payment under 10 U.S.C. 1095 were provided as claimed and were provided in a manner consistent with permissible terms and conditions of the third party payer's plan. This is the sole purpose for which patient care records will be made available. Records not needed for this purpose will not be made available.

§ 220.6 Certain payers excluded.

(a) *Medicare and Medicaid.* Under 10 U.S.C. 1095(d), claims for payment from the Medicare or Medicaid programs (titles XVIII and XIX of the Social Security Act) are not authorized.

(b) *Supplemental plans.* CHAMPUS (see 32 CFR part 199) supplemental plans and income supplemental plans are excluded from any obligation to pay under 10 U.S.C. 1095.

(c) *Third party payer plans prior to April 7, 1986.* 10 U.S.C. 1095 is not applicable to third party payer plans which have been in continuous effect without amendment or renewal since prior to April 7, 1986. Plans entered into, amended or renewed on or after April 7, 1986, are subject to 10 U.S.C. 1095.

(d) *Third party payer plans prior to November 5, 1990, in connection with outpatient care.* The provisions of 10 U.S.C. 1095 and this section concerning outpatient services are not applicable to third party payer plans:

(1) That have been in continuous effect without amendment or renewal since prior to November 5, 1990; and

(2) For which the facility of the Uniformed Services or other authorized representative for the United States makes a determination, based on documentation provided by the third party payer, that the policy or plan clearly excludes payment for such services. Plans entered into, amended or renewed on or after November 5, 1990, are subject to this section, as are prior plans that do not clearly exclude payment for services covered by this section.

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§ 220.7 Remedies and procedures.

(a) Pursuant to 10 U.S.C. 1095(e)(1), the United States may institute and prosecute legal proceedings against a third party payer to enforce a right of the United States under 10 U.S.C. 1095 and this part.

(b) Pursuant to 10 U.S.C. 1095(e)(2), an authorized representative of the United States may compromise, settle or waive a claim of the United States under 10 U.S.C. 1095 and this part.

(c) The authorities provided by 31 U.S.C. 3701, *et seq.*, 28 CFR part 11, and 4 CFR parts 101-104 regarding collection of indebtedness due the United States shall be available to effect collections pursuant to 10 U.S.C. 1095 and this part.